

2009 H1N1 Influenza Immunization Screening and Consent Form

Name (please print)	Date of Birth	Age	Date of Immunization
Address	City		State
Zip			
Parent/Guardian (please print)	Sex	Patient Phone	Medicare Claim Number
	F M		
Name of HMO/MCO, If Member	Provider's Name		
HMO/MCO Policy #, If Known	Provider's Address		
Clinic/Office Site Where Vaccine is Administered	Mother's Maiden Name: (optional)		

Indications	Have you (your child) had any vaccine within the last 28 days, including the 2009 H1N1 flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you (your child) between 6 months and 24 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you work in healthcare or emergency medical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For ages 25 - 64 years, do you have a chronic or immunosuppressive medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you a household contact or caregiver for children younger than 6 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contraindications	Are you sick with fever today?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had a serious reaction to the nasal spray or flu shot vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have a severe allergy to eggs, a severe allergy to a component of the vaccine, or a anaphylactic allergy to latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever had Guillain Barre' Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LAIV Contraindications	Do you have close contact with anyone with a severely weakened immune system or are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	For children ages 2 - 4 years, has this child had asthma or wheezing episodes in the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is this child or teen to be vaccinated receiving long term aspirin treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you recently or are you now taking antiviral medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Influenza Consent

I have read, or had explained to me, the Vaccine Information Sheet (VIS) about 2009 H1N1 influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that 2009 H1N1 influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

_____ Signature of Recipient (parent or guardian)	_____ Date				
Area Below to be Completed by Vaccinator					
Administration Site	<input type="checkbox"/> Left Deltoid	<input type="checkbox"/> Right Deltoid	<input type="checkbox"/> Left Thigh	<input type="checkbox"/> Right Thigh	<input type="checkbox"/> Nasal
Dosage	<input type="checkbox"/> 0.5 ml	<input type="checkbox"/> 0.25ml	<input type="checkbox"/> LAIV		
VIS Date _____	Manufacturer & Lot Number _____				
<input type="checkbox"/> I have reviewed side effects with patient (parent or guardian)					
Vaccinator Signature _____					
Next Immunization Date:	<input type="checkbox"/> Next Year	<input type="checkbox"/> In 4 weeks	<input type="checkbox"/> Other		